

REFERENCE TITLE: insurance; network plan; definition

State of Arizona
House of Representatives
Forty-ninth Legislature
First Regular Session
2009

HB 2145

Introduced by
Representative McLain

AN ACT

AMENDING SECTION 20-1379, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-1379, Arizona Revised Statutes, is amended to
3 read:

4 20-1379. Guaranteed availability of individual health insurance
5 coverage: prior group coverage: definitions

6 A. Every health care insurer that offers individual health insurance
7 coverage in the individual market in this state shall provide guaranteed
8 availability of coverage to an eligible individual who desires to enroll in
9 individual health insurance coverage and shall not:

10 1. Decline to offer that coverage to, or deny enrollment of, that
11 individual.

12 2. Impose any preexisting condition exclusion for that coverage.

13 B. Every health care insurer that offers individual health insurance
14 coverage in the individual market in this state shall offer all policy forms
15 of health insurance coverage that are designed for, **THAT** are made generally
16 available and actively marketed to and **THAT** enroll both eligible or other
17 individuals. A health care insurer that offers only one policy form in the
18 individual market complies with this section by offering that form to
19 eligible individuals. A health care insurer also may comply with the
20 requirements of this section by electing to offer at least two different
21 policy forms to eligible individuals as provided by subsection C of this
22 section.

23 C. A health care insurer shall meet the requirements prescribed in
24 subsection B of this section if:

25 1. The health care insurer offers at least two different policy forms,
26 both of which are designed for, **ARE** made generally available and actively
27 marketed to and enroll both eligible and other individuals.

28 2. The offer includes at least either:

29 (a) The policy forms with the largest and next to the largest earned
30 premium volume of all policy forms offered by the health care insurer in this
31 state in the individual market during a period not to exceed the preceding
32 two calendar years.

33 (b) A choice of two policy forms with representative coverage,
34 consisting of a lower level of coverage policy form and a higher level of
35 coverage policy form, each of which includes benefits that are substantially
36 similar to other individual health insurance coverage offered by the health
37 care insurer in this state and each of which is covered by a method that
38 provides for risk adjustment, risk spreading or a risk spreading mechanism
39 among the health care insurer's policies.

40 D. The health care insurer's election pursuant to subsection C of this
41 section is effective for policies offered during a period of at least two
42 years.

43 E. If a health care insurer offers individual health insurance
44 coverage in the individual market through a network plan, the health care
45 insurer may do both of the following:

1 1. Limit the individuals who may be enrolled under health insurance
2 coverage to those who live, reside or work within the service area for a
3 network plan.

4 2. Within the service area of a network plan, deny health insurance
5 coverage to individuals if the health care insurer has demonstrated, if
6 required, to the director that both:

7 (a) The health care insurer will not have the capacity to deliver
8 services adequately to additional individual enrollees because of the health
9 care insurer's obligations to existing group contract holders and enrollees
10 and individual enrollees.

11 (b) The health care insurer is applying this paragraph uniformly to
12 individuals without regard to any health status-related factor of the
13 individuals and without regard to whether the individuals are eligible
14 individuals.

15 F. A health care insurer may deny individual health insurance coverage
16 in the individual market to an eligible individual if the health care insurer
17 demonstrates to the director that the health care insurer:

18 1. Does not have the financial reserves necessary to underwrite
19 additional coverage.

20 2. Is denying coverage uniformly to all individuals in the individual
21 market in this state pursuant to state law and without regard to any health
22 status-related factor of the individuals and without regard to whether the
23 individuals are eligible individuals.

24 G. If a health care insurer denies health insurance coverage in this
25 state pursuant to subsection F of this section, the health care insurer shall
26 not offer that coverage in the individual market in this state for one
27 hundred eighty days after the date the coverage is denied or until the health
28 care insurer demonstrates to the director that the health care insurer has
29 sufficient financial reserves to underwrite additional coverage, whichever is
30 later.

31 H. An accountable health plan as defined in section 20-2301 that
32 offers conversion policies on an individual or group basis in connection with
33 a health benefits plan pursuant to this title is not a health care insurer
34 that offers individual health insurance coverage solely because of the offer
35 of a conversion policy.

36 I. Nothing in this section:

37 1. Creates additional restrictions on the amount of the premium rates
38 that a health care insurer may charge an individual for health insurance
39 coverage provided in the individual market.

40 2. Prevents a health care insurer that offers health insurance
41 coverage in the individual market from establishing premium rates or
42 modifying otherwise applicable copayments or deductibles in return for
43 adherence to programs of health promotion and disease prevention.

1 3. Requires a health care insurer that offers only short-term limited
2 duration insurance limited benefit coverage or to individuals and no other
3 coverage to individuals in the individual market to offer individual health
4 insurance coverage in the individual market.

5 4. Requires a health care insurer offering health care coverage only
6 on a group basis or through one or more bona fide associations, or both, to
7 offer health insurance coverage in the individual market.

8 J. A health care insurer shall provide, without charge, a written
9 certificate of creditable coverage as described in this section for
10 creditable coverage occurring after June 30, 1996 if the individual:

11 1. Ceases to be covered under a policy offered by a health care
12 insurer. An individual who is covered by a policy that is issued on a group
13 basis by a health care insurer, that is terminated or not renewed at the
14 choice of the sponsor of the group and where the replacement of the coverage
15 is without a break in coverage is not entitled to receive the certification
16 prescribed in this paragraph but is instead entitled to receive the
17 certification prescribed in paragraph 2 of this subsection.

18 2. Requests certification from the health care insurer within
19 twenty-four months after the coverage under a health insurance coverage
20 policy offered by a health care insurer ceases.

21 K. The certificate of creditable coverage provided by a health care
22 insurer is a written certification of the period of creditable coverage of
23 the individual under the health insurance coverage offered by the health care
24 insurer. The department may enforce and monitor the issuance and delivery of
25 the notices and certificates by health care insurers as required by this
26 section, section 20-1380, the health insurance portability and accountability
27 act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations
28 adopted to implement the health insurance portability and accountability act
29 of 1996.

30 L. Any health care insurer, accountable health plan or other entity
31 that issues health care coverage in this state, as applicable, shall issue
32 and accept a certificate of creditable coverage of the individual that
33 contains at least the following information:

34 1. The date that the certificate is issued.

35 2. The name of the individual or dependent for whom the certificate
36 applies and any other information that is necessary to allow the issuer
37 providing the coverage specified in the certificate to identify the
38 individual, including the individual's identification number under the policy
39 and the name of the policyholder if the certificate is for or includes a
40 dependent.

41 3. The name, address and telephone number of the issuer providing the
42 certificate.

43 4. The telephone number to call for further information regarding the
44 certificate.

1 5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For THE purposes of this subdivision, "eighteen months" means five hundred forty-six days.

5 (b) Both the date that the individual first sought coverage, as
6 evidenced by a substantially complete application, and the date that
7 creditable coverage began.

8 6. The date creditable coverage ended, unless the certificate
9 indicates that creditable coverage is continuing from the date of the
10 certificate.

11 7. The consumer assistance telephone number for the department.

12 8. The following statement in at least fourteen point type:

13 Important Notice!

Keep this certificate with your important personal records to protect your rights under the health insurance portability and accountability act of 1996 ("HIPAA"). This certificate is proof of your prior health insurance coverage. You may need to show this certificate to have a guaranteed right to buy new health insurance ("Guaranteed issue"). This certificate may also help you avoid waiting periods or exclusions for preexisting conditions. Under HIPAA, these rights are guaranteed only for a very short time period. After your group coverage ends, you must apply for new coverage within 63 days to be protected by HIPAA. If you have questions, call the Arizona department of insurance.

26 M. A health care insurer has satisfied the certification requirement
27 under this section if the insurer offering the health benefits plan provides
28 the certificate of creditable coverage in accordance with this section within
29 thirty days after the event that triggered the issuance of the certificate.

N. Periods of creditable coverage for an individual are established by the presentation of the certificate described in this section and section 20-2310. In addition to the written certificate of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, a health care insurer shall take into account all information that the insurer obtains or that is presented to the insurer on behalf of the individual.

39 0. A health care insurer shall calculate creditable coverage according
40 to the following rules:

41 1. The health care insurer shall allow an individual credit for each
42 day the individual was covered by creditable coverage.

2. The health care insurer shall not count a period of creditable coverage for an individual enrolled under any form of health insurance coverage if after the period of coverage and before the enrollment date there

1 were sixty-three consecutive days during which the individual was not covered
2 by any creditable coverage.

3 3. The health care insurer shall not include any period that an
4 individual is in a waiting period or an affiliation period for any health
5 coverage or is awaiting action by a health care insurer on an application for
6 the issuance of health insurance coverage when the health care insurer
7 determines the continuous period pursuant to paragraph 1 of this subsection.

8 4. The health care insurer shall not include any period that an
9 individual is waiting for approval of an application for health care
10 coverage, provided the individual submitted an application to the health care
11 insurer for health care coverage within sixty-three consecutive days after
12 the individual's most recent creditable coverage.

13 5. The health care insurer shall not count a period of creditable
14 coverage with respect to enrollment of an individual, ~~if~~, after the most
15 recent period of creditable coverage and before the enrollment date,
16 sixty-three consecutive days lapse during all of which the individual was not
17 covered under any creditable coverage. The health care insurer shall not
18 include in the determination of the period of continuous coverage described
19 in this section any period that an individual is in a waiting period for
20 health insurance coverage offered by a health care insurer, is in a waiting
21 period for benefits under a health benefits plan offered by an accountable
22 health plan or is in an affiliation period.

23 6. In determining the extent to which an individual has satisfied any
24 portion of any applicable preexisting condition period the health care
25 insurer shall count a period of creditable coverage without regard to the
26 specific benefits covered during that period.

27 P. An individual is an eligible individual if, on the date the
28 individual seeks coverage pursuant to this section, the individual has an
29 aggregate period of creditable coverage as defined and calculated pursuant to
30 this section of at least eighteen months and all of the following apply:

31 1. The most recent creditable coverage for the individual was under a
32 plan offered by:

33 (a) An employee welfare benefit plan that provides medical care to
34 employees or the employees' dependents directly or through insurance,
35 reimbursement or otherwise pursuant to the employee retirement income
36 security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code
37 sections 1001 through 1461).

38 (b) A church plan as defined in the employee retirement income
39 security act of 1974.

40 (c) A governmental plan as defined in the employee retirement income
41 security act of 1974, including a plan established or maintained for its
42 employees by the government of the United States or by any agency or
43 instrumentality of the United States.

44 (d) An accountable health plan as defined in section 20-2301.

(e) A plan made available to a person defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (d) or a dependent pursuant to section 36-2901, paragraph 6, subdivision (e) of a person eligible under section 36-2901, paragraph 6, subdivision (d), provided the person was most recently employed by a business in this state with at least two but not more than fifty full-time employees.

2. The individual is not eligible for coverage under:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

(c) Part A or part B of title XVIII of the social security act.

(d) Title 36, chapter 29, except coverage to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or any other plan established under title XIX of the social security act, and the individual does not have other health insurance coverage.

3. The most recent coverage within the coverage period was not terminated based on any factor described in section 20-2309, subsection B, paragraph 1 or 2 relating to nonpayment of premiums or fraud.

4. The individual was offered and elected the option of continuation coverage under a COBRA continuation provision pursuant to the consolidated omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a similar state program.

5. The individual exhausted the continuation coverage pursuant to the consolidated omnibus budget reconciliation act of 1985.

Q. Notwithstanding subsection P of this section, an individual is an eligible individual if:

1. The individual is an individual enrollee in a health care services organization that is domiciled in this state on the date that the health care services organization is declared insolvent, including any health care services organization that is not an accountable health plan as defined in section 20-2301.

2. The individual's coverage terminates during the delinquency proceeding, after the health care services organization is declared insolvent.

3. The individual satisfies the requirements of an eligible individual as prescribed in this section other than the required period of creditable coverage.

R. Notwithstanding subsection P of this section, a newborn child, adopted child or child placed for adoption is an eligible individual if the child was timely enrolled and otherwise would have met the definition of an eligible individual as prescribed in this section other than the required period of creditable coverage and the child is not subject to any preexisting

condition exclusion or limitation if the child has been continuously covered under health insurance coverage or a health benefits plan offered by an accountable health plan since birth, adoption or placement for adoption.

S. If a health care insurer imposes a waiting period for coverage of preexisting conditions, within a reasonable period of time after receiving an individual's proof of creditable coverage and not later than the date by which the individual must select an insurance plan, the health care insurer shall give the individual written disclosure of the insurer's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:

1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.

2. The basis for the insurer's determination and the source and substance of any information on which the insurer has relied.

3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the insurer's determination, including an explanation of any procedures for submission and appeal.

T. This section and section 20-1380 apply to all health insurance coverage that is offered, sold, issued, renewed, in effect or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

U. For the purposes of this section and section 20-1380 as applicable:

1. "Affiliation period" has the same meaning prescribed in section 20-2301.

2. "Bona fide association" means, for health care coverage issued by a health care insurer, an association that meets the requirements of section 20-2324.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

1 (h) A health benefits risk pool operated by any state of the United
2 States.

3 (i) A health plan offered pursuant to title 5, chapter 89 of the
4 United States Code.

5 (j) A public health plan as defined by federal law.

6 (k) A health benefit plan pursuant to section 5(e) of the peace corps
7 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through
8 2523).

9 (l) A policy or contract, including short-term limited duration
10 insurance, issued on an individual basis by an insurer, a health care
11 services organization, a hospital service corporation, a medical service
12 corporation or a hospital, medical, dental and optometric service corporation
13 or made available to persons defined as eligible under section 36-2901,
14 paragraph 6, subdivision (b), (c), (d) or (e).

15 (m) A policy or contract issued by a health care insurer or an
16 accountable health plan to a member of a bona fide association.

17 4. "Delinquency proceeding" has the same meaning prescribed in section
18 20-611.

19 5. "Different policy forms" means variations between policy forms
20 offered by a health care insurer, including policy forms that have different
21 cost sharing arrangements or different riders.

22 6. "Genetic information" means information about genes, gene products
23 and inherited characteristics that may derive from the individual or a family
24 member, including information regarding carrier status and information
25 derived from laboratory tests that identify mutations in specific genes or
26 chromosomes, physical medical examinations, family histories and direct
27 analysis of genes or chromosomes.

28 7. "Health care insurer" means a disability insurer, group disability
29 insurer, blanket disability insurer, health care services organization,
30 hospital service corporation, medical service corporation or a hospital,
31 medical, dental and optometric service corporation.

32 8. "Health status-related factor" means any factor in relation to the
33 health of the individual or a dependent of the individual enrolled or to be
34 enrolled in a health care services organization including:

35 (a) Health status.

36 (b) Medical condition, including physical and mental illness.

37 (c) Claims experience.

38 (d) Receipt of health care.

39 (e) Medical history.

40 (f) Genetic information.

41 (g) Evidence of insurability, including conditions arising out of acts
42 of domestic violence as defined in section 20-448.

43 (h) The existence of a physical or mental disability.

44 9. "Higher level of coverage" means a policy form for which the
45 actuarial value of the benefits under the health insurance coverage offered

1 by a health care insurer is at least fifteen per cent more than the actuarial
2 value of the health insurance coverage offered by the health care insurer as
3 a lower level of coverage in this state but not more than one hundred twenty
4 per cent of a policy form weighted average.

5 10. "Individual health insurance coverage" means health insurance
6 coverage offered by a health care insurer to individuals in the individual
7 market but does not include limited benefit coverage or short-term limited
8 duration insurance. A health care insurer that offers limited benefit
9 coverage or short-term limited duration insurance to individuals and no other
10 coverage to individuals in the individual market is not a health care insurer
11 that offers health insurance coverage in the individual market.

12 11. "Limited benefit coverage" has the same meaning prescribed in
13 section 20-1137.

14 12. "Lower level of coverage" means a policy form offered by a health
15 care insurer for which the actuarial value of the benefits under the health
16 insurance coverage is at least eighty-five per cent but not more than one
17 hundred per cent of the policy form weighted average.

18 13. "Network plan" means a health care plan provided by a health care
19 insurer under which the financing and delivery of health care services are
20 provided, in whole or in part, through a defined set of providers EITHER
21 under contract with ~~the~~ A health care insurer LICENSED PURSUANT TO CHAPTER 4,
22 ARTICLE 3 OF THIS TITLE OR UNDER CONTRACT WITH A HEALTH CARE INSURER in
23 accordance with the determination made by the director pursuant to section
24 20-1053 regarding the geographic or service area in which a health care
25 insurer may operate.

26 14. "Policy form weighted average" means the average actuarial value of
27 the benefits provided by a health care insurer that issues health coverage in
28 this state that is provided by either the health care insurer or, if the data
29 are available, by all health care insurers that issue health coverage in this
30 state in the individual health coverage market during the previous calendar
31 year, except coverage pursuant to this section, weighted by the enrollment
32 for all coverage forms.

33 15. "Preexisting condition" means a condition, regardless of the cause
34 of the condition, for which medical advice, diagnosis, care, ~~or~~ or treatment
35 was recommended or received within not more than six months before the date
36 of the enrollment of the individual under the health insurance policy or
37 other contract that provides health coverage benefits. A genetic condition
38 is not a preexisting condition in the absence of a diagnosis of the condition
39 related to the genetic information and shall not result in a preexisting
40 condition limitation or preexisting condition exclusion.

41 16. "Preexisting condition limitation" or "preexisting condition
42 exclusion" means a limitation or exclusion of benefits for a preexisting
43 condition under a health insurance policy or other contract that provides
44 health coverage benefits.

1 17. "Short-term limited duration insurance" means health insurance
2 coverage that is offered by a health care insurer, that remains in effect for
3 no more than one hundred eighty-five days, that cannot be renewed or
4 otherwise continued for more than one hundred eighty days and that is not
5 intended or marketed as health insurance coverage subject to guaranteed
6 issuance or guaranteed renewal provisions of the laws of this state but that
7 is creditable coverage within the meaning of this section and section
8 20-2301.